Primary Care Physician Advisory Committee
Meeting Minutes
March 19, 2014

Members Present: Kathryn Koncsol-Banner, MD, Co-Chair; Thomas Bledsoe, MD; Stanley Block, MD; Mark Braun, MD; Michael Felder, DO, MA (call-in); Elizabeth Lange, MD; Diane Siedlecki, MD; Richard Wagner, MD; Guests: Deidre Gifford; Rachel Trippett; Sherry Schlib; Alyssa DaFonseca; Gus Mundocchia; Jill D'Errico.

Members and Alternates Unable to Attend: David Bourassa, MD, Co-Chair; Gregory Allen, Jr., DO; David Ashley, MD; Munawar Azam, MD; Jeffrey Borkan, MD; Denise Coppa, PhD, RNP; Steven DeToy; Michael Fine, MD, Director of HEALTH; Nitin Damle, MD; Sara Fessler, MD; Patricia Flanagan, MD; Cynthia Holzer, MD, CMD; Steven Kempner, MD; Albert Puerini Jr., MD; Anne Neuville, RNP; John Solomon, DO; Patrick Sweeny, MD, PhD, MPH; Jennifer Thiesen; Newell Warde, PhD.

Open Meeting/Old Business: PCPAC Co-Chair, Dr. Banner, called the meeting to order at 7:38 AM. Notes were discussed and accepted at 7:40.

First Agenda: Nicole Alexander, MD

An overview of the Getting to Zero Campaign:

- Dr. Alexander gave an overview of the Getting to Zero campaign and HEALTH's role in it. The goal is for no new native transmissions per year and a comprehensive effort to address this with a focus on prevention, treatment, and care. Rhode Island did exceed the national goal of a 25% reduction in cases, and had a 35% reduction last year.
- Data was also presented. The highest rate of infection and exposure is among men sleeping with men (62%), and there also is a lot of co-infection with syphilis (35%).
- Dr. Alexander stressed the importance for PCP's to continue to stress routine HIV testing. It is estimated that the 25% of cases that are unaware contribute to 54% of new infections.
- A new law was passed in 2007 for mom's/babies to get tested, and at Woman and Infant's, the rate of testing went from 53% to 100%.
- The suggestion is routine testing starting at age 13, at least once, and there is a preference that providers use the opt-out format rather than the opt-in format.
- Category C specific funding from the CDC was awarded to Rhode Island and one of the key aspects was the return to care component. HEALTH gets referrals to follow up with infected patients but is looking for ways to engage the PCP to keep individuals in care.
- Use of the fourth generation test helps reduce false positives; however the need to test everyone still outweighs the risk of the false positives.
- The issue arose that for many, cost may be a factor as they have to reach their deductible. HEALTH does have a program if the individual can't pay for the test, a sticker can be placed on the lab sheet and it will be paid through a grant.

Suggestions from PCPAC members:

- Incentivize testing and add Hepatitis C to this.
- If individuals do opt-out, they should be given information on anonymous testing.
- Along with new testing, the suggestion was made to look backwards from the new cases.

Questions:

1. Are these numbers the new transmissions or old infections that were never diagnosed?

Each case is evaluated in detail and the information varies among cases, but looking at previous tests is important but not always available.

2. In how many of the new cases did the individual who gave them the infection know? Half

3. How can we maintain adolescent and adult confidentiality?
This is a consistent challenge.

4. It seems that people today are less fearful of contracting HIV then they were 20 years ago, what is being done to address this?
Health has launched media campaigns using formative research. These include-a campaign to accept lifestyle and encourage safety, the read between the lines campaign, and increasing the number of free and anonymous testing sites from 40-69 in the state.

Second Agenda: James McDonald, MD

Availability of substance abuse treatment:

- HEALTH is concerned about the availability and access to substance abuse treatment.
- BHDDH has said the treatment is readily available. The obstacles may be if the person is willing to be treated, monetary, or the level of addiction.
- Another issue is if you do get treated, but do not do the required follow-up, you are placed at the bottom of the list making it difficult to seek treatment again.

Suggestions from PCPAC members:

- It would be good to have more specific demographic information on drug use so doctor's could focus their attention where needed. Often people who need treatment may not have the means to travel to get it.
- Having a clearinghouse for information and established relationship with providers and services may help some of these issues.
- It would be interesting if substance abuse services were not applied to deductibles, as it is considered by some to be almost a preventative care- for the health/productivity of all.
- We may want to look at the model of the Mass. Psychiatry Access Program which provides a team funded by the state to answer calls from providers on psychiatric care.
- The Rhode Island Primary Care Association does have a psychiatry referral and acts as a clearinghouse for information through partnerships.

Questions:

1. Why are some providers distributing buprenorphine but other are not?
For one doctor, there was a rate of patients that needed it, so the practice decided to do take the measures to prescribe this. It is difficult to distinguish between those who are in pain, those who are selling it, and those truly addicted.

2. The ER barrier to treatment is daunting. What can be done to help this, and how can PCP's receive follow up information on their patients?
Butler has been effective at communicating with PCP's on notifications of treatment, but a separate consent is needed for alcohol/ substance abuse (It is a quality indicator for them).

Announcement- A training on risk assessment mitigation and will be occurring twice due to some secured grant funding. More details to follow.
Meeting adjourned at 8:45 AM
Next Meeting: April 16 at 7:30 AM in 401.